Renaissance Rehabilitation Center

1322 St. Charles Street • P.O. Box 3259 • Houma, LA 70361
(985) 876-9555
Fax: (985) 876-0180
www.renaissancerehab.org

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PATIENT INFORMATION

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NAME:_____ DATE OF BIRTH:_____ AGE:_____ SEX:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

SS:_____ HOME PHONE:_____ CELL:_____

MARITAL STATUS: MARRIED____ SINGLE____ DIVORCED____ WIDOWED____ E-MAIL:_____

EMERGENCY CONTACT:_____ PHONE:_____

THIS CONTACT IS PERMITTED TO DISCUSS THE MEDICAL CONDITIONS OF THE PATIENT:_____

RELATIONSHIP TO PATIENT:_____

EMPLOYER:_____ WORK PHONE:_____

ADDRESS:_____ CITY/STATE:_____ ZIP:_____

DATE OF INJURY:_____

INJURY: WORK RELATED:_____ AUTO ACCIDENT:_____ OTHER:_____

REFERRING PHYSICIAN:_____ DATE OF NEXT APPOINTMENT:_____

DO YOU HAVE LEGAL REPRESENTATION? YES____ NO____

NAME:_____ PHONE:_____

HAVE YOU BEEN A PATIENT HERE BEFORE? YES___ NO___

ARE YOU CURRENTLY RECEIVING HOME HEALTH CARE? YES_____ NO_____

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INSURANCE INFORMATION

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PRIMARY INSURANCECARRIER:_____

INSURED:_____ SS#:_____ DOB:_____

RELATIONSHIP TO PATIENT:_____

EMPLOYER:_____ EMPLOYER PHONE:_____

SECONDARY INSURANCE:_____

INSURED:_____ SS#:_____ DOB:_____

POLICY #_____ GROUP #:_____

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RESPONSIBLE PARTY AGREEMENT

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I UNDERSTAND THAT AS A SERVICE TO ME, RENAISSANCE REHABILITATION CENTER WILL COMPLETE AND SUBMIT MY INITIAL INSURANCE CLAIMS FREE OF CHARGE.

I UNDERSTAND MY INSURANCE IS NOT A PROMISE OF PAYMENT AND IT IS MY RESPONSIBILTY TO MAKE SURE MY ACCOUNT IS PAID IN FULL. RENAISSANCE REHABILITATION CENTER DOES NOT ACCEPT RESPONSIBILITY FOR COLLECTING CLAIMS OR NEGOTIATING A SETTLEMENT ON A DISPUTED CLAIM.

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF NON-COVERED CHARGES.

WE WILL BILL THE PATIENT AFTER INSURANCE PAYS THEIR PORTION. WE EXPECT TO RECEIVE PAYMENT EACH MONTH FROM PATIENT TO AVOID THE ACCOUNT FROM BEING TURNED OVER TO COLLECTION.

MONTHLY FINANCIAL ARRANGEMENTS MUST BE MADE WITHIN 30 DAYS OF RECIEPT OF YOUR STATEMENT OR ACCOUNT MAY BE PLACED FOR COLLECTION.

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO RENAISSANCE REHABILITATION CENTER FOR SERVICES. FURNISHED BY THAT PROVIDER.

THE OFFICE OF RENAISSANCE REHABILITATION CENTER HAS THE RIGHT TO REFUSE OR STOP ANY CREDIT ESTABLISHMENT IN THIS OFFICE AT ANY ITEM, FOR ANY REASON DEEMED NECESSARY.

THE FOREGOING AUTHORITY SHALL CONTINUE IN FORCE UNTIL REVOKED BY ME IN WRITING. A PHOTOSTATIC COPY HEREOF MAY SERVE AS AN ORIGINAL.

SIGNATURE:_____ DATE:_____

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MEDICAL HISTORY

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Existing Conditions:

Allergies	□Yes	□No
Anemia	□Yes	□No
Anxiety	□Yes	□No
Arthritis	□Yes	□No
Asthma	□Yes	□No
Autoimmune Disorder	□Yes	□No
Cancer	□Yes	□No
Cardiac Condition	□Yes	□No
Cardiac Pacemaker	□Yes	□No
Chemical Dependency	□Yes	□No
Circulation Problems	□Yes	□No
Currently Pregnant	□Yes	□No
Depression	□Yes	□No
Diabetes	□Yes	□No
Dizzy Spells	□Yes	□No
Emphysema/Bronchitis	□Yes	□No
Fractures	□Yes	□No
Fibromyalgia	□Yes	□No
Gallbladder Problems	□Yes	□No
Headaches	□Yes	□No
Hearing Impairment	□Yes	□No
Hepatitis	□Yes	□No
High Cholesterol	□Yes	□No
High/Low Blood Pressure	□Yes	□No
HIV/AIDS	□Yes	□No
Incontinence	□Yes	□No
Kidney Problems	□Yes	□No
Metal Implants	□Yes	□No
MRSA	□Yes	□No
Multiple Sclerosis	□Yes	□No
Muscular Disease	□Yes	□No
Osteoporosis	□Yes	□No
Parkinson's	□Yes	□No
Rheumatoid Arthritis	□Yes	□No
Seizures	□Yes	□No
Smoking	□Yes	□No
Speech Problems	□Yes	□No
Strokes	□Yes	□No
Thyroid Disease	□Yes	□No
Tuberculosis	□Yes	□No
Vision Problems	□Yes	□No

Describe any other conditions or precautions:

Fall History

Injury as a result of a fall in the past year	☐Yes	☐No
Two or more falls in the past year?	☐Yes	☐No

Surgical History

Body Region:________________ Surgery Type:________________ Date:________

Body Region:________________ Surgery Type:________________ Date:________

Body Region:________________ Surgery Type:________________ Date:________

Body Region:________________ Surgery Type:________________ Date:________

Body Region:________________ Surgery Type:________________ Date:________

Body Region:________________ Surgery Type:________________ Date:________

Current Medications:

Drug:____________ Dosage______ Frequency______ Route:____ Reason Taking______

Drug:____________ Dosage______ Frequency______ Route:____ Reason Taking______

Drug:____________ Dosage______ Frequency______ Route:____ Reason Taking______

Drug:____________ Dosage______ Frequency______ Route:____ Reason Taking______

Drug:____________ Dosage______ Frequency______ Route:____ Reason Taking______

Drug:____________ Dosage______ Frequency______ Route:____ Reason Taking______

________________________ ________________

Patient Signature **Date**

Renaissance Rehabilitation Center of Houma, Inc.
Notice of Privacy Practices

Uses and Disclosers

Treatment: Your health information may be used by our staff members to evaluate your health, make a diagnosis and provide treatment. For example, any notes from your doctor, nurses or any member of your medical team, will be recorded in your medical records and available to any health professional involved in your treatment or family member helping with your care.

Payment: We will use and disclose your health information to your health plan, automobile insurers, worker compensation companies or attorneys. For example, we may have to obtain authorization from your insurance company before providing treatment. We will submit the bills and maintain records of payments from your insurance.

Health Care Operations: We will use and disclose your health information to conduct our daily operations, including proper administration of records, evaluation of quality, and to assess your care.

Required By Law: Your health information may be disclosed to public health agencies to support government audits and inspections, to facilitate investigations and to comply with government-mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law for any certain communicable diseases

Other Uses and Disclosures require you authorization: Disclosure of your health information or its use for any purpose other then those listed above may require your specific written authorization. This authorization can be revoked in writing for any future uses and disclosers.

Additional Uses of Information

Appointment Reminders: Your health information will used to provide you with appointment reminders. (voicemail, postal service or e-mail)

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights sections above. We may disclose information to family members, friends or other person involved with your healthcare or payment of healthcare, only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of a family member, your personal representative or another person responsible for your care, of your location, general condition or death. If you or present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such use or disclosure. We will use our professional judgment in disclosing any information concerning your treatment and protect your privacy.

Patients Rights:

You have certain rights under the federal privacy standards. They include:

1. The right to request restrictions on the use and disclosure of your health information
2. The right to receive confidential communications concerning your condition and treatment
3. The right to inspect and copy information
4. The right to amend or submit corrections to your information
5. The right to receive a report of how and to whom your information has been disclosed.
6. The right to receive a printed copy of this notice.

Request to Inspect Protected Health Information

You may generally inspect or copy your health information that we maintain. As permitted by federal regulations, we require that a request be submitted in writing. You may obtain a form to request access to your records by contacting Renaissance Rehabilitation's medical records department. Your request will generally be approved unless there are legal or medical reasons to deny the request.

Comments or Complaints

If you would like to submit a comment or complaint about our privacy practices or if you feel your privacy rights have been violated, you should call the matter to our attention by contacting us via phone, mail or e-mail describing the cause of your concern to our compliance officer listed below.

Our Legal Duties

We are required by law to protect and maintain privacy of your health information and provide you with a notice of privacy practices.

We are required to abide by the privacy policies and practices that are outlined in this notice.

We reserve the right change our privacy practices and the terms of this Notice at any time, provided any changes are permitted by law. Any significant changes made to our privacy practices will be made available upon request.

Implemented: 01/01/2010

Compliance Officer: Linda Hemphill

Address: **Renaissance Rehabilitation**
1322 St. Charles St
Houma, LA 70360

Phone: (985)876-9555
Fax: (985)876-0180

Patient:_____ **Date:**_____